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Fifty individuals were interviewed about the complete trajectory of their involuntary admission experience—from being transferred to hospital and held to post discharge experience. Four themes emerged from a qualitative analysis: feeling trapped and coerced, feeling disengaged and unsupported, admission-induced distress, and person-centered encounters.

EXPERIENCES OF INVOLUNTARY HOSPITAL ADMISSION IN THE REPUBLIC OF IRELAND

MURPHY ET AL.

Service Users' Experiences of Involuntary Hospital Admission Under the Mental Health Act 2001 in the Republic of Ireland

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Patient perceptions, Patient rights, Involuntary admission, Mental Health Act, Tribunal, Law, Ireland, Quality of care

Objective: The objective of the study was to explore the experiences of individuals admitted to the hospital involuntarily under the Mental Health Act 2001 in the Republic of Ireland.

Methods: In this qualitative descriptive study, 50 individuals who had been involuntarily admitted to a hospital underwent face-to-face semi-structured interviews approximately three months after revocation of the involuntary admission order. Data were analyzed by using an inductive thematic process.

Results: Participants reported mixed experiences over the course of the admission, with both positive and challenging aspects. Participants reported feeling coerced, disempowered, and unsupported at various stages of the admission and highlighted the long-term deleterious impact on their psychological well-being. However, participants also described encounters with individuals who endeavored to initiate a collaborative, informative, and compassionate approach. Four key themes emerged consistently across the trajectory of participants' involuntary admission experiences: feeling trapped and coerced, feeling disengaged and unsupported, admission-induced distress, and person-centered encounters.

Conclusions: This qualitative study of service users' views across the entire trajectory of their involuntary admission identified a number of factors that should be addressed to reduce the negative impact of involuntary admission. A multifaceted strategy could include ongoing education and training of all stakeholders in the principles and practices of person-centered

care, repeated provision of accessible information and emotional support to service users during all stages of involuntary admission, and a shift in culture to one that minimizes the traumatic impact of forced detention on individuals' psychological well-being.

Internationally, legislative processes and procedures governing the involuntary detention of people with a mental disorder differ greatly (1). However, common across most jurisdictions is a concern about the human rights aspect of involuntary admission (2,3) and the potential for the admission process to have a significant negative impact on an individual's psychological well-being (4–6).

In the Republic of Ireland, the legislative framework within which a person with a mental disorder can be admitted and treated involuntarily is the Mental Health Act (MHA) 2001 (7). This legislation, which in 2006 replaced the Mental Treatment Act of 1945 (8), strengthened legal oversight of the involuntary admission process and ensured that Ireland was on a par with international standards of human rights (9,10). Individuals admitted under the MHA 2001 are required to have a mental disorder resulting in a serious likelihood of the person's causing immediate harm to self or others or to have judgment so impaired by the mental disorder that failure to admit would likely lead to a serious deterioration of the person's condition (7,11). [Additional information about the MHA 2001 is included in an online supplement to this article.]

In 2015, the involuntary admission rate to psychiatric inpatient units in the Republic of Ireland was 51.5 per 100,000 population (12), virtually unchanged from the rate noted just prior to implementation of the MHA 2001 (13). In other European countries, rates of involuntary admission vary greatly, from six per 100,000 population per year in Portugal to 218 per 100,000 per year in Finland (14). However, comparisons between countries should be interpreted with caution because of heterogeneous study designs and differences between countries in legislative frameworks (15). For example, in the Republic of Ireland, there is no legal provision for community treatment orders.

International research has documented that service users who are detained involuntarily express concerns about violations of their autonomy, human rights, personal integrity, and self-efficacy (6,16–19). Although positive experiences and person-centered care have been reported by service users (17,20), the pervasive narrative is one of fear, distress, and loss; service users report feeling disempowered, coerced, disconnected from decision-making processes (17,21–25), and traumatized by their experience (6,26–33).

Research examining involuntary admission under the MHA 2001 in the Republic of Ireland has been mainly quantitative. Although this research has provided valuable information on the negative impact of detention on relationships with the treating psychiatrist and family members (34), rates of detention (35–39), the relationship between detention and diagnosis (40–42), and factors that may predict service users' attitudes to involuntary admission (34,43,44) or future engagement with services (45), there is limited research using qualitative methodologies to explore the experiences of service users. In addition, most international qualitative studies draw on small samples (eight to 25 participants) and focus on one aspect of the detention experience, such as the hospital experience (22,25).

In this large qualitative study, we aimed to comprehensively explore service users' experiences throughout the trajectory of their involuntary admission, including transfer and post-discharge phases. Participants were interviewed three months after revocation of the involuntary admission order, at which point they were considered optimally able to reflect on their experience.

Methods

A qualitative descriptive study design was used because it provided the flexibility needed to explore the experiences of people admitted involuntarily under the MHA 2001 throughout the trajectory of the involuntary admission process. In addition, this design allowed for the emergence of any unanticipated findings.

Participants were recruited from a larger cohort of 156 individuals who had taken part in a quantitative prospective study of attitudes toward admission and care, which was conducted with a representative cohort of service users from three inpatient psychiatric units in the Republic of Ireland (46). Data were collected during 2011 and 2014 by using in-depth, semi-structured, audio-recorded, face-to-face interviews, guided by an interview schedule. In total, 50 participants (29 men and 21 women) were interviewed. The sample size was determined by a desire to achieve maximum variation in the sample rather than to provide an epidemiologically representative sample.

With assistance from the computer software package Nvivo (47), thematic analysis (48) of the data was conducted. Ethical approval for the study was obtained from the Research Ethics Committees of National University of Ireland Galway, Galway University Hospitals Clinical Research Ethics Committee, and Roscommon Hospital Ethics Committee. [Additional information about the research process, inclusion criteria, and ethical procedures is included in the online supplement.]

Results

Participants' Demographic Profile

Table 1 presents information about the 50 participants who were interviewed. For seven participants, the involuntary admission was initiated from within the approved center. Forty-three participants were transferred from the community to the hospital under the MHA 2001 (37 were subsequently detained, and six were held in the approved center for a period of 24 hours but were not found to meet the criteria for detention). The most common diagnosis was non-affective psychotic disorder. Thirteen participants had a diagnosis of schizophrenia. For 24 participants, this was their first admission under the MHA 2001. Forty-two participants identified their nationality as Irish, with other participants identifying as English (N=3), Iranian (N=1), Malaysian (N=1), Spanish (N=1), French (N=1), and Slovenian (N=1).

Themes

Analysis of the data resulted in the following four themes: feeling trapped and coerced, lack of emotional and informational support, admission-induced trauma, and person-centered encounters. Tables 2–5 present selections of participants' statements from the interview that most effectively capture and articulate these themes and their primary concerns. Two authors (RM and AH) reached consensus on the inclusion of these quotes as representative of the themes.

Feeling trapped and coerced.

Two-thirds of participants (N=34) reported feeling confined and coerced at various times over the course of their admission experience (Table 2). Of the 50 participants, 43 were transferred to the hospital by the National Assisted Admissions Team or the Gardai Síochána (Irish police). During initial transfer and admission to the hospital, 18 of these participants reported that the stakeholders involved in the transfer process took a firm stance and sometimes a physically forceful stance. Many participants reported being unaware of the forthcoming plans for their admission; 12 described feeling shocked and confused by the unexpected arrival of the National Assisted Admissions Team at their home, workplace, or other public place (Table 2, quote A1); 15 reported feeling “ambushed” and “surrounded”

(A2 and A3); and 20 recounted that they were offered no alternative options to hospitalization and that their opinion and concerns went unheard (A4 and A5). For a number of participants, the coercive manner adopted was intensified by the involvement of the Gardai (N=35) (A6 and A7), the use of physical force to transport them to the hospital (N=8) (A8), and the use of ultimatums (N=3) (A9 and A10). Under the circumstances they described, these participants felt that they had no choice but to comply reluctantly with hospital admission.

Feelings of being trapped and coerced during their hospital stay also emerged in the narratives of 26 participants. Rather than being a place of therapeutic refuge and compassion, the hospital was likened by 17 participants to imprisonment (A11 and A12). From these participants' perspective, the duration of their involuntary admission was shrouded in uncertainty and the admission impinged on their civil rights and offered limited opportunities for involvement, negotiation, or personal control (A13). Twenty-two participants were also of the view that medication was the primary treatment available, and they believed that they had no choice but to comply and take the medication prescribed to ensure their discharge (A14 and A15). Such was the fear of not being discharged that 16 participants spoke of compliance with language describing a feeling of being psychologically "ground down" and beaten by the system (A14 and A15).

Lack of informational and emotional support.

Thirty-four participants also described a lack of informational and emotional support (Table 3). At various stages during their involuntary admission, participants reported that the reasons for their admission (N=24) or their plan of care (N=14) were not sufficiently explained (B1 and B2) and that there was limited consideration of their opinion, needs, or concerns (B3 and B4). Twenty-three of the 50 participants attended a mental health tribunal or had the experience of the preparatory process for such a tribunal. Ten of these participants reported receiving little information about the upcoming tribunal and as a result lacked an awareness of the purpose and format of the tribunal (B5 and B6). Consequently, eight of these participants believed that the view of the psychiatrist was given primacy over their opinion at the tribunal; 11 stated that tribunal members did not adequately facilitate their involvement in the tribunal process (B7 and B8).

In addition to lack of information, 23 of the 50 participants described experiencing a deficit in emotional support at perceived critical time points, including their initial transfer to the hospital and before, during, and after their tribunal. In particular, participants who were physically restrained during their transfer to the hospital (N=8) recalled that the absence of a familiar person was extremely disconcerting and frightening at this time (B9). Three participants also described feeling scared and anxious about their upcoming tribunal and its outcome and feeling as if they had no one to talk to or support them at this time (B10). Although this was not the experience of all participants, these participants spoke of the need for someone to explain and help them feel part of the tribunal process and someone to talk to about the process (B11).

Admission-induced trauma.

Nineteen of the 50 participants indicated that aspects of their involuntary admission had a detrimental and prolonged negative impact on their mental health (Table 4). Twelve participants likened the impact of their detention and admission to that of enduring a trauma (C1) and described feeling worse after discharge from the hospital than prior to admission (C2). These participants recalled experiencing panic, flashbacks, and nightmares about events that occurred during the transfer and admission process, including persistent thoughts about their experience or nightmares regarding being physically restrained or coerced in their own

homes (C3, C4, and C5). Six participants spoke of a debilitating level of apprehension and self-surveillance that permeated their lives post-discharge and described living in a constant state of fear that they could lose their liberty and be readmitted at any moment (C6). These participants reported experiencing significant panic when they observed or were in contact with people or objects that reminded them of their admission. For example, seeing a vehicle that was similar to the one used for transport to the hospital induced panic for one participant (C7). In addition, six participants were of the view that they were being monitored or watched at home (C8) and that all their actions and responses were filtered and interpreted by family and others through the lens of mental illness. Such was some participants' level of apprehension that four reported withdrawing physically or emotionally from family or social activities (C9). Six others spoke of having reduced confidence about trusting their own judgment and of no longer feeling in control of their life (C10).

Person-centered encounters.

Eighteen participants' narratives were interspersed with examples of interactions with people who initiated a collaborative, informative, and compassionate approach (Table 5). For six of these participants, transfer to the hospital was conducted in a calm and considerate manner, in which they felt actively included, listened to, and cared for (D1 and D2). Similarly, 16 participants recalled that at times they felt supported during their time in the hospital, eight reported that they received sufficient information about their care and treatment (D3 and D4), and five stated that the role of the mental health tribunal was explained in an accessible way (D5). However, rather than reflecting a systemic culture, experiences of humanizing care frequently appeared to depend on a particular staff member. As a result, these positive and empowering experiences were not consistently evident across all stages of participants' involuntary admission.

Discussion

The findings of this study indicate that participants' principal concerns regarding their involuntary hospital admission were about violations of their autonomy, limited provision of information and support, and the detrimental impact that the involuntary admission process had on their psychological well-being. These findings reiterate concerns identified in other studies in which service users' experiences of involuntary admission were characterized by coercion and diminishment of their autonomy, human rights, and personal integrity (16,20,49); feelings of not being listened to, cared for, or actively involved in decision making (16,19); and limited provision of information and the exacerbating effect that this can have on an already diminished sense of control (16).

The long-term adverse effects of coercive treatments have been identified in previous research (6,27,50). However, the participants' narratives in this study differ. Unlike participants in previous research, participants in this study did not specifically link their experiences of trauma to specific interventions, such as seclusion or coercive administration of intramuscular medication. Instead, participants were of the view that the entire process of involuntary admission had induced a traumatic effect. The severity and persistence of this trauma were reflected in participants' description of their post-discharge worry and panic, with features of post-traumatic stress disorder, including increased anxiety, hyper-vigilance, and flashbacks. The participants' narratives reaffirm the need for mental health services staff to be as cognizant of these additional deleterious effects on emotional and psychological well-being, which are specifically associated with the experience of detention, as they are of other patient safety concerns, such as risks of self-harm (51–53). Although there is a need to improve the entire process of detention, participants' narratives particularly highlighted the

need for significant improvement in the critical pre-admission phase, when individuals are assessed and transferred to a hospital. Improving pre-admission practices has the potential to positively affect the hospital experience and reduce trauma. It is equally important to implement interventions among persons voluntarily admitted to hospitals, because research demonstrates that those admitted voluntarily may also feel coerced during their hospital stay (54–56).

The care of individuals who are involuntarily detained is a complex and difficult process to navigate successfully. However, the findings of this and similar studies (16,19) attest to the fact that if person-centered collaborative care and respect are embedded systemically, then some of the adverse impact of involuntary detention can be mitigated. Successful implementation of such an approach requires all staff involved to be mindful of the need for ongoing respectful dialogue and promotion of choice and control when possible and the importance of repeatedly providing accessible information over the course of the person's involuntary admission. Open acknowledgment and discussion of the person's experience have been shown to mitigate the potentially traumatizing nature of involuntary admissions (57,58) and to induce increased acceptance of compulsory treatment, feelings of empowerment, and restored self-value and self-worth (19).

The participants' narratives also highlighted the need to develop supportive strategies to minimize the persistent state of apprehension and self-surveillance that permeated people's lives long after their discharge from the hospital. In addition, further research is needed to identify the most effective and cost-effective interventions to reduce the negative emotional impact of involuntary admission.

The qualitative design of this study provided needed insight into service users' experiences of involuntary admission in the Republic of Ireland, which to date have been predominantly explored through quantitative methods. It also provided important information about individuals' perspectives on the entire process, especially in relation to the pre and post hospital experience, which are critical time points. However, because participants were recruited with purposive sampling as opposed to stratified randomization, selection bias was possible, and findings may not be universally representative or applicable within the Republic of Ireland or to services in other countries. In the absence of a control group, it is not possible to say to what extent participants' experience of coercion was directly related to having an involuntary hospital admission rather than to being in an approved center. As we did not conduct subgroup analyses, neither is it possible to determine whether perceptions of those detained after an initial voluntary admission or those experiencing an involuntary admission for the first time differed from the perceptions of the overall sample. Such analyses will be the focus of a future qualitative study examining service user experience of involuntary admission under the MHA 2001.

Conclusions

Despite the potential beneficial effects that hospital admission can have on mental well-being, this qualitative study of service users' views across the trajectory of their involuntary admission identified a number of factors that had a negative impact on their psychological well-being. These included disempowering and controlling practices, feeling uninvolved in decision making, and a lack of accessible information and emotional support. Many of these issues can be addressed. Indeed, some participants indicated that a person-centered approach can be achieved in the pressured and difficult context of involuntary admission. However, consistently applying such an approach across the entire trajectory of involuntary admission is challenging and will require a multifaceted strategy that includes ongoing education and training of all stakeholders in the principles and practices of person-centered care and a shift

among all stakeholders to an attitude that recognizes the traumatic and debilitating impact of forced detention on personhood and psychological well-being. Although this study was undertaken in the Republic of Ireland, given the many commonalities across jurisdictions in mental health legislation regarding procedures for detention and review of involuntary detention, our findings are potentially informative to mental health services in other jurisdictions.

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TABLE 1. Patient and admission characteristics for 50 participants interviewed about their admissions under the Mental Health Act (MHA) 2001

Characteristic	N	%
Sex		
Men	29	58
Women	21	42
Age		
Men		
18–24	2	4
25–34	6	12
35–44	10	20
45–54	6	12
55–64	5	10
>65	0	—
Women		
18–24	2	4
25–34	4	8
35–44	7	14
45–54	3	6
55–64	2	4
>65	3	6

Type of involuntary admission		
From the community and detained (Section 14 Form 6 completed)	37	74
Originally a voluntary admission and an involuntary admission later initiated from within the approved center (Section 23/24 Form 13 completed)	7	14
Held in the approved center for 24 hours but not found to meet criteria for detention N of previous detentions under the MHA 2001	6	12
0	24	48
1	9	18
2 or 3	7	14
4 or 5	5	10
6 or 7	2	4
8 or 9	1	2
10–15	0	—
16 or 17	1	2
Diagnosis		
Nonaffective psychotic disorder ^a	26	52
Affective psychotic disorder ^b	16	32
Alcohol use disorder ^c	3	6
Other ^d	2	4
No diagnosed disorder	2	4
Diagnosis not available (no permission	1	2

to access clinical notes)

^aIncludes schizophrenia, schizoaffective disorder, brief psychotic disorder, and schizophreniform disorder

^bIncludes bipolar affective disorder and major depressive disorder

^cAdmitted under the MHA 2001 because of presentation of comorbid subjective depressive symptoms, deliberate self-harm, or suicidal ideation with intent

^dIncludes substance-induced psychotic disorder and anorexia nervosa

TABLE 2. Selected quotes related to the theme of feeling trapped and coerced from interviews with participants about their admission under the Mental Health Act 2001

Quote #	Quote
A1	So, and then for me to have the arrival of these people [admission team] at your door to take you off is very hard. . . . Like you can't even control your own house any more. (Female, age 41, ID3)
A2	It's [being detained] very bizarre. It's very frightening. . . . You're very confused, and you want to sort of stand up and try to defend yourself, but you know that it's pointless, because you're surrounded. They [admission team] had me ambushed, surrounded [in own home]. (Female, age 46, ID44)
A3	I went to the door with the phone still to me ear, opened the door. [Name] was standing there, my ex, and there was, I don't know, maybe three men and a lady, maybe four. I don't know. . . . So, I said to my mother on the phone, "Oh my God, I said, the cavalry is here." (Male, age 47, ID14)
A4	He [the general practitioner] was basically telling me to go to hospital. He didn't give me any choice. He didn't say anything about medication, about counseling. He just said, "I think you should go to hospital." I just went along with that. I don't know why I did. I was in shock. I'm still in shock in a way. (Female, age 36, ID41)
A5	They [admission team] came into my garden where I was working. I heard my dog barking. I came in, three of them and this woman and I didn't know [if they were] politicians or what they wanted, and they showed me the cards [ID] and said they were from [the National Admission Team] whatever and they had to bring me into the unit [hospital], and I said to them I had responsibilities, that I

- couldn't just go like that, but they didn't . . . they weren't interested. (Male, age 56, ID23)
- A6 There was one [police] who came into the restaurant but there was another two accompanying him and then they brought me in the car back to the station. Interviewer: And what did they say to you? Can you remember? Response: Just that I had to come with them, and I knew if I didn't they were going to get assertive. So, I left with them, and when they got me in the [police] car they kind of put their two hands on both my arms so I was kind of held down so I knew I had to go with them. (Female, age 46, ID44)
- A7 I came in by the Guards [Irish police], yes. They came into the pub and took me out. (Male, age 49, ID2)
- A8 Suddenly a woman called [name] came into my room, and then a few men followed her, and they just dragged me. Like, they took my wrists and ankles and just pulled me down. (Female, age 30, ID19)
- A9 At that stage, I almost felt like I was violated. I think that was one of the words I used, that I was basically like taken. Someone [admission team] came to my house, came into the house, and then said, "You're coming with us. We want you to come," but [pause] it's always that "but" and that sort of silent threat, that sort of coercion. (Male, age 47, ID14)
- A10 They [admission team] come in and say, "If you don't come with us, we'll get the Guards [Irish police] involved and we'll put handcuffs on you and bring you." This kind of thing, and they actually did that once. (Female, age 41, ID3)
- A11 I suppose when you're involuntary, having that sort of label on you and knowing that you're trapped there [in the hospital]. . . . feel very much like you've had your human rights taken away, you feel imprisoned, and you kind of feel, as I said before, a second-class citizen (Female, age 33, ID24)
- A12 I just wasn't respected, and I was in prison, and I was forced to do whatever they asked me to do, and if I don't, then they would take my light away or they would take my mobile phone away. (Female, age 26, ID48)
- A13 I just felt I hadn't any control of what was going to happen with me, how long I was going to stay in [the hospital] or anything. I think they [treatment team] had the decision made up already beforehand and that was it. Even if I was progressing in my health as the days went on, they wouldn't release me. (Female, age 24, ID9)
- A14 Well, I preferred the [name of a drug] over two weeks, but then when it was changed I went through every drug on the market, and now we finally found [name of another drug] which Dr. [name] wanted me on in the first place and wouldn't let me leave hospital without me going on it. So, I was beaten into it in the end. (Female, age 41, ID3)
- A15 Hospitals grind you down. You're just ground down into nothing until the doctor feels that you're supplicant or whatever the word is. . . . Until you're nothing, until you agree with them. So, the doctors will keep you here until you agree with them. They break you down like that. (Male, age 32, ID12)

TABLE 3. Selected quotes related to the theme of lack of informational and emotional support from interviews with participants about their admission under the Mental Health Act 2001

Quote #	Quote
B1	No, nothing was explained to me. . . . No, no one even said where my family had gone to, you know, why was I even in there [hospital]? . . . I didn't realize until I was, I suppose, in the vehicle on the way going down there [to the hospital] and even at that stage I wasn't even sure where I was going. (Female, age 20, ID40)
B2	No [response to question about being provided with information], not really. I did. I knew I was in hospital. I had done the interview [with the psychiatrist]. I wasn't quite sure why I was there. I was saying, "Why am I here?" You know, because I believed I was fine at the time. I wasn't quite sure why I was there. (Female, age 46, ID44)
B3	My dignity and respect weren't, if you like. . . . They were only interested in

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- doing their own work. They didn't take my considerations into account at all, or they had no interest. I told them that I had my animals, my feed, and all this. They weren't interested. They didn't want to hear it. (Male, age 56, ID23)
- B4 He [psychiatrist] spoke down to me. I said, "I'm going home full-stop." He said, "Oh no you're not." I needed compassion at that time. I needed him to say we're just going to try and help you. Let's see how it goes. "Oh no you're not. I can tell you you're not." [emphasizing the demand of the doctor] In that tone of voice. (Female, age 56, ID20)
- B5 I was given no notice of anything and told nothing. Not prepared [for the tribunal], didn't even know the solicitor was coming. . . . I was just sitting down on the chair beside the bed relaxing, when in comes this man and he said, "I'm your solicitor. I'm going to represent you at the tribunal," and I said fine. He introduced himself. Sure I didn't know what was happening, [name] about tribunals. . . . the day that the independent psychiatrist arrived, I never knew he was coming either. Never told, had no time to prepare. Went inside to this doctor, never saw him in my life before. He told me he was from Dublin and that he was the independent psychiatrist, and I asked him would he be present at my tribunal and he said he didn't know. (Female, age 60, ID30)
- B6 I don't know. I think I was told what it [the tribunal] was for. I was never asked to go to the tribunal or whatever. I don't understand what the tribunal was anyway. (Male, age 23, ID37)
- B7 I kind of got the feeling that, you know, sort of medics [doctors] stick with medics, as it were, and in tribunal situations . . . you kind of get the feeling that they would take the medics' view over the patients' view, because they are medics and it's a medical situation. Maybe you know they're not really listening to the patient. (Female, age 33, ID24).
- B8 I don't really get to say anything in there. So if I go to say anything, Dr. [consultant's name] will butt in and . . . and you felt like you didn't get a chance to say anything only what the solicitor said. (Female, age 68, ID4)
- B9 I was sure that someone I knew would come and help me. Trying to find a voice, like, I remember lying down on the floor, all the men [members of the assisted admission team] pushing me down, and I was trying to find a voice I could recognize, someone I knew to say, "Please, help me. I haven't done anything wrong." (Female, age 30, ID19)
- B10 So, I kept getting these letters [about the tribunal] then, all the time getting these letters. I'd come back from lunch, and there would be a letter on my pillow, which was very annoying because there was no one to talk to about it. (Female, age 60, ID30)
- B11 They could at least have someone there to explain things a bit better because you don't get a good explanation about it [role of the tribunal]. You get told that you're going involuntary and that's it. You've no opinion like. In this day and age, I just felt that was wrong. . . . Just to have someone there to explain things a bit better really. At least that way then you know what's going on. (Male, age 23, ID37)

TABLE 4. Selected quotes related to the theme of admission-induced trauma from interviews with participants about their admission under the Mental Health Act 2001

Quote #	Quote
C1	Leaving the hospital . . . that's even worse, because that's when the trauma comes in and the fear comes into your normal life. You have to go to work and keep living this like big trauma caused by these people [involved in involuntary admission experience], and this trauma is the one that's going to cause more severe and more problems. (Female, age 30, ID19)
C2	If I didn't have those [outpatient appointments and group sessions], I would have been a hell of a lot worse, because, as I said, when I came out of here [hospital] I felt I needed more therapy than when I came in. You know what I mean, I felt there were more issues because it was something that, you know, it [experience of detention] was like a nightmare. (Male, age 47, ID14)

- C3 So, when I came home into my own environment, it was like then I had to go through posttraumatic stress of being in the hospital, and within a few days I did bring terrible anxiety over me. . . . I just went through a period of horrendous anxiety. (Female, age 56, ID20)
- C4 It was really traumatic. I have nightmares about it [being restrained]. . . . Then sometimes I wake up in the middle of the night screaming. It was the most traumatic and stressful experience, so it's like it left a scar in my past, and it's now sometimes I get repeated thoughts about it, and then it's like flashbacks. (Female, age 26, ID48)
- C5 Well, then I started going back to my room trying to sleep and that was this place where people [admissions team] handcuffed me, treated me with so much aggression. I couldn't sleep. I had lots of fear in my own room because of them. . . . I just kept remembering all that happened and all they did to me, and I just couldn't feel safe. I couldn't feel safe in my room. I couldn't feel safe in the world. Because you have to feel maybe they can come in again. I mean you just don't feel safe like. Like, if that happened one time, it could happen another one. Like, fear of something could happen. (Female, age 30, ID19)
- C6 I suppose it's the fear of the reoccurrence of it [involuntary admission]. The fear of the fact that this abuse or whatever can happen again. That other people can decide how well I am without me expressing it. Other people can take charge, you know. (Female, age 40, ID22)
- C7 So, I seen this van [similar to the vehicle used for transporting the person to hospital] turning down the drive, and I'm thinking to myself, I'm actually trembling inside. I froze thinking hang on, this van is coming to take me away. That's just the way I felt. I still wasn't inside my door, and all of a sudden there was a van turning down toward the house. It didn't come into my place. It went next door, but it was just that feeling, you know? I remember feeling that cold feeling of hang on, you're still not out [of the hospital]. (Male, age 47, ID14)
- C8 I felt I couldn't actually say anything ever again without it being taken the wrong way. (Male, age 47, ID14)
- C9 My husband thinks I should be back in here after a weekend out because I was quiet. . . . I didn't want to say anything and be back there [hospital] again, you know. (Female, age 42, ID16)
- C10 I don't trust my own thinking. I don't feel capable of making decisions because I'm unsure of whether it's right or wrong now, as where before I trusted my own gut instinct. . . . That for me has gone now. I'm uneasy most of the time. (Female, age 40, ID22)

TABLE 5. Selected quotes related to the theme of person-centered encounters from interviews with participants about their admission under the Mental Health Act 2001

Quote #	Quote
D1	I suppose it started off with the Gardaí [Irish police], and they took a very caring attitude. They seemed concerned. . . . When I got here [hospital] then, it was the nurse that actually brought me in, that kind of ran me through everything that kind of signed me in to the ward. It was caring as well. She was actually talking to me. . . . I just think that engagement in itself helped relax me. (Male, age 37, ID5)
D2	To be honest, it was just like me walking in myself. That's how it felt. It didn't feel bad. It really didn't, in fairness. I was treated just like any other person that would walk in off the street, I'd say. They weren't bad-minded to me or talk down to me or, they just treated me like a normal person, which was good, you know. (Female, age 44, ID50)
D3	And then she said, "If you ever need to talk, just get the nurses to get me, and I'll talk to you." . . . She's very down-to-earth. Very civil and everything. . . . Because she'd talk to you like she was a friend of yours. (Male, age 47, ID33)
D4	And they're willing to listen, and even though they go by the book as well, they're willing to adjust. (Male, age 39, ID29)
D5	No, I was given plenty of information [about detention]. I had somebody come to

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me and talk to me. They gave me the mental health booklet. Somebody talked to
me about the tribunal. Nurses came over to me regularly and asked me what was
going on. They were very insightful at the time, I found, regarding what was
happening to me and what would possibly happen next. (Male, age 37, ID5)

ID is the code number assigned to each person interviewed